POST TERM PREGNANCY

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Abstract. *Timely onset of labor is an important determinant of perinatal outcome. Although it has long been known that there is a small absolute increase in perinatal mortality as pregnancy is extended beyond the estimated due date, the optimal gestational age to begin formal fetal monitoring (eg, nonstress test, biophysical profile) and the optimal gestational age to schedule delivery, and not continuing expectant management and formal fetal monitoring is more controversial.*

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The incidence of post-term pregnancies may vary across populations, in part due to regional differences in management of pregnancies beyond the expected due date. Accurate determination of gestational age is essential for accurate diagnosis and appropriate management of late and post-term pregnancies. Antenatal fetal care and labor induction have been evaluated as strategies to reduce the risks of perinatal morbidity and mortality associated with late and post-term pregnancies. The purpose of this document is to review the current understanding of late and post-term pregnancies and provide management recommendations that have been supported by appropriately conducted research.

The following definitions describe subgroups of postterm pregnancies:

• Post-term – ≥42+0 weeks of pregnancy (i.e. ≥294 days from the first day of the last menstrual period and ≥14 days from the expected date of birth).

• Late term – from 41+0 to 41+6 weeks of pregnancy.

In post-term pregnancy, diagnostic tests may include:

• Ultrasound

• Watching how your baby's heart rate responds to activity

• Checking the amount of amniotic fluid

• The goal of pregnancy tolerance prevention is to prevent problems and deliver a healthy baby. Postterm pregnancy is associated with increased perinatal morbidity and mortality. There is an increased risk of stillbirth and neonatal death, and an increased risk of death in the first year of life. The increased mortality is thought to be associated with factors such as uteroplacental insufficiency, meconium aspiration, and intrauterine infection.

Risk factors:

• A previous post-term pregnancy increases the risk of recurrence in subsequent pregnancies.

• Primogeniture.

• High maternal BMI is associated with longer gestations and increased rates of labor induction. Increased pre-pregnancy weight and increased maternal weight increase the risk of post-term birth.

• Genetic factors. There is an increased risk of post-term pregnancy for mothers who were themselves born post-term, and twin studies also suggest a genetic role.

• Advanced maternal age.

Symptoms of post-term pregnancy:

• In a post-term baby, the amount of subcutaneous fat and reduced soft tissue mass are below normal.

• The skin may be loose, flaky and dry.

• Fingernails and toenails may be longer than usual and yellow in color due to meconium.

Signs of post-term pregnancy:

• Before birth, fetal mobility may be reduced.

• Decreased amniotic fluid volume may cause the uterus to shrink in size.

• Meconium-stained amniotic fluid can be seen when membranes rupture.

Increasing evidence shows that labor induction policies are associated with fewer perinatal deaths and fewer caesarean sections compared with expectant management. Gynecologists recommend that women be offered induction therapy after 41 weeks between 41+0 and 42+0 weeks to avoid the risk of postpartum hemorrhage. -full-term pregnancy, primarily increased intrauterine fetal death. Before formal induction of labor, women should be offered a vaginal examination with sweeping of membranes. If a woman chooses not to have an induction, this decision should be respected and monitoring should be intensified from 42 weeks of gestation with cardiotocography at least twice weekly and ultrasound assessment of the maximum depth of the amniotic pool.

Fetal morbidity also increases with higher risks:

• Meconium aspiration.

• Macrosomia and large children lead to:

• Prolonged labor.

• Cephalo-pelvic disproportion.

• Shoulder dystocia.

• Birth trauma resulting, for example, in damage to the brachial plexus or cerebral palsy.

For diagnosis, fetal movements may be counted. This tracks your baby's kicks and movements. A change in quantity or frequency may indicate that a developing child is under stress. Non-stress testing. This test shows how your baby's heart rate increases as he moves. This is a sign of your baby's well-being. Biophysical profile. This test combines a non-stress test with ultrasound to assess your baby's well-being. Ultrasound. This test uses high-frequency sound waves and a computer to produce images of blood vessels, tissues, and organs. Ultrasound is also used to monitor the growth of your developing baby. Doppler blood flow studies. This is a type of ultrasound that uses sound waves to measure blood flow. The test is usually used if a developing child is not growing normally. If tests find that it is unhealthy for the developing baby to remain in the womb, labor can be induced to deliver the baby. Once labor begins, your baby's heart rate will need to be monitored using an electronic monitor. This is done to monitor changes in heart rate caused by low oxygen levels. You may need a caesarean section if your baby's condition changes. Amnio infusion is sometimes used during labor if there is very little amniotic fluid or if the baby is pressing on the umbilical cord. A sterile liquid is injected into the uterus through a hollow tube (catheter). The fluid helps replace amniotic fluid and softens the baby and the umbilical cord. Women with a post-term pregnancy, especially with a large baby, are more likely to have:

Longer labor

• Forceps or vacuum assisted delivery
• Vaginal rupture or trauma
• C-section
• Infection, wound complications and bleeding after birth

There are also risks to the unborn and newborn baby if the pregnancy is post-term. These include:

• Stillbirth and death of newborn
• Problems with the placenta
• Decreased amniotic fluid
• The child may stop gaining weight or even lose weight
• Birth trauma, if the child is large
• The baby inhales the fluid containing the first stool (meconium aspiration).
• Low blood sugar (hypoglycemia) because the child has too little glucose.

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